Table Number of new patients and gonococcal isolates between 1983 and 1989

Groups	*1983*	*1984*	*1985*	*1986*	*1987*	*1988*	*1989*
Total new patients	38,106	37,579	38,971	39,853	37,970	31,470	21,487
Gonococcal isolates	2,688	2,349	1,769	1,327	766	600	521

44% in 1983 to 53% in 1989 ($R = 0{\cdot}90$, $p < 0{\cdot}01$). The proportion of heterosexual females has remained relatively constant at 31% ($R = 0{\cdot}66$, $p < 0{\cdot}2$), whilst the proportion who are homosexual males has declined from 27% in 1983 to 16% in 1989 ($R = -0{\cdot}85$, $p < 0{\cdot}02$; fig). This decline has been observed in other London[2] and New York[3] clinic populations.

Although the declining rates are encouraging, no room for complacency exists. Of the 83 homosexual men with gonorrhoea diagnosed in 1989, 69% were diagnosed in the second half of the year. Of these 83 men, 62 (75%) reported having had recent unprotected anal intercourse.

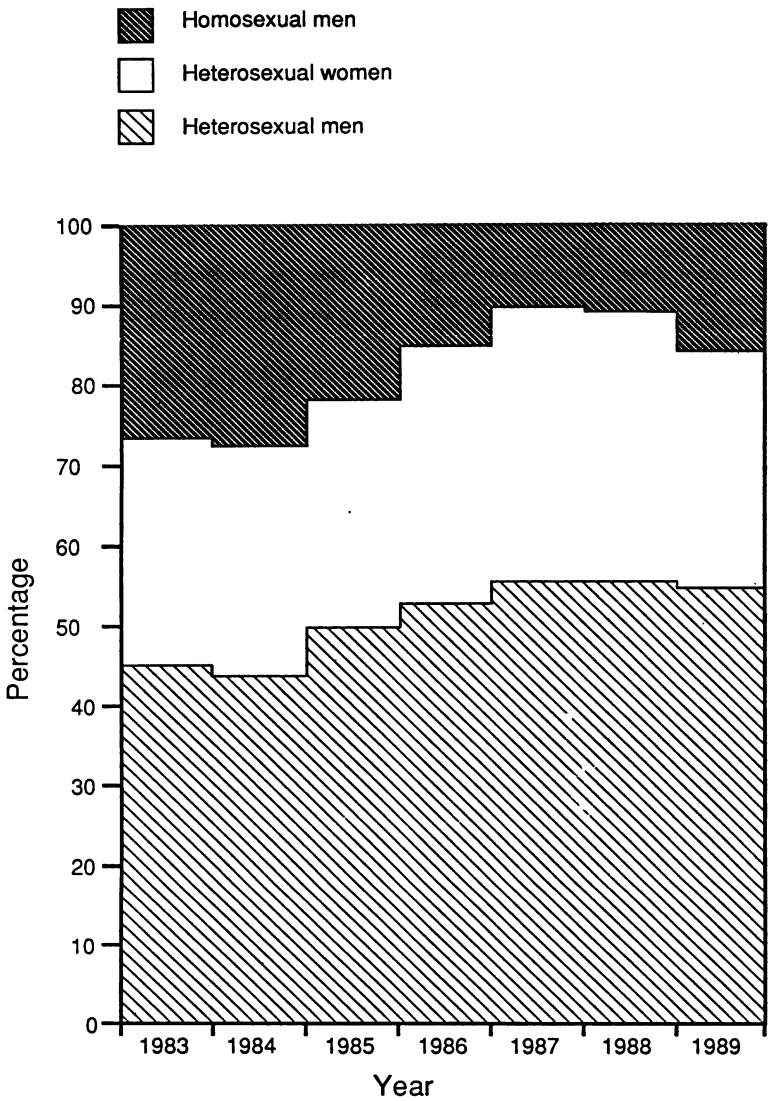

Figure Percentage of individuals with positive gonococcal isolates between 1983 and 1989 by gender and sexual orientation.

Nine (11%) had used condoms which broke during anal intercourse, whilst 12 (14%) reported unprotected oral intercourse as their only risk of gonorrhoea. Twenty two patients had previous HIV1 antibody tests of which six were positive (27% of those tested). Five of these six patients reported recent unprotected anal intercourse while the sixth used a condom which broke during anal intercourse. Two patients had positive HIV1 antibody tests taken after the diagnosis of gonorrhoea was made. Similarly 10 (12%) of these patients had positive syphilis serology, of whom two reported never having been treated for syphilis. Finally, 63 of the 83 had been investigated for hepatitis B: 32% had evidence of previous infection and two were chronic carriers of hepatitis B surface antigen.

These figures suggest that groups of heterosexual and homosexual men continue to have unprotected sexual intercourse with casual contacts. Though changes have been observed in both groups these trends suggest that there is a continuing need for health education.

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Isolate of TET M-containing *Neisseria gonorrhoeae* (TRNG) in Spain

In February 1985 *Neisseria gonorrhoeae* with resistance to tetracycline (TRNG) encoded on a 25·2

megadalton transmissible plasmid,[1] was isolated in the United States of America.[2] These strains of TRNG were found in England and the Netherlands in 1988.[3,4]

We now present the first TRNG isolate in Spain, from a prostitute woman from Madrid; she was treated with spectinomycin. The isolate of *N. gonorrhoeae* was resistant to tetracycline (Minimal Inhibitory Concentration 16 mg/l), sensitive to penicillin (MIC 0·06 mg/l), spectinomycin (MIC 16 mg/l) and ceftriaxone (MIC 0·0015 mg/l), and moderately sensitive to cefoxitin (MIC 0·5 mg/l).

The plasmid analysis[5] shows two plasmids, of 25·2 and 2·6 megadaltons; digestion of plasmid deoxyribonucleic acid with Hinc II and Sma I shows a band pattern different from the one found when a 24·5 megadalton plasmid (transfer plasmid) was digested.

Auxotype and serotype were determined as has been previously described;[6] the isolate belonged to class-Pro/Bpyst.

A rapid international spread of TRNG may be occurring as we predicted recently.[7]

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Workload in genitourinary medicine clinics in England

One of the criteria used to assess workloads in genitourinary clinics is based on the reports of clinic attendances, that is, new cases, return visits and diagnoses. Yet there does not appear to be an agreed uniform approach to calculating these figures between different clinics, making comparisons of workloads difficult to interpret.

When to reregister patients (and thus create a new visit and a new diagnosis) is an area open to individual interpretation. A dilemma often arises in cases of chronic or recurrent conditions like candidiasis, recurrent non-specific urethritis, genital warts, etc.

Different clinic practices may also contribute to false impressions of workload. For example, considering the fact that many of our patients are employed and/or have young children, we operate a fairly liberal policy of allowing patients to phone for results where the doctor considers this appropriate. This obviously creates a lot of work for reception staff, who still have to retrieve case notes from filing and locate results, and often have to ask a doctor either for a comment or to talk to the patient. Thus, although we are providing an optimal patient oriented facility much of this work is not included in assessment of workload for the clinic. Conversely, a clinic that insists on a visit for results will show higher clinic attendance figures.

A clinic, like ours, that provides a full colposcopy service through to cold coagulation, loop excision or laser therapy, hardly has its workload adequately represented by a single diagnosis of C11 when the patient attends with genital warts and is subsequently managed by us for an abnormal smear. A clinic that does not even do cytology would apparently have a similar workload to us—based on diagnoses alone.

With the imminent National Health Service review and an apparent decrease in clinic attendance numbers, despite increased workload due to the complexity of the current conditions,[1] there is pressure on clinics to institute measures to get numbers to reflect the work being done. In future it is likely that greater credit and resources will be given to clinics that show high new patient attendance numbers and a high new patient to follow up attendance ratio. To our knowledge no consensus on performance indicators in genitourinary medicine has yet been reached but attendance and ratios are likely to be major considerations. It is essential that our practice is represented in a comprehensive, accurate and work sensitive way to reflect true workload and changing trends. Clinic variance in registration and reregistration policies will make comparisons inaccurate and regional planning difficult.

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Syphilis among heterosexuals

We read with interest the paper by Dr van den Hoek and colleagues[1] and have therefore performed a survey to determine whether acquisition of syphilis at our unit is associated with prostitution or drug abuse.

The case notes of all patients attending our clinic between 1985 and 1989 with primary, secondary or early latent syphilis (less than one year's duration) were reviewed retrospectively. The following clinical details were recorded: sex; sexual orientation; history of prostitution; history of drug abuse; whether infection contracted in UK or abroad. These details are summarised in the table.

No patients gave a history of prostitution or drug abuse. As has been noted in other studies the number of homo/bisexual men with infectious syphilis has greatly decreased and the proportion of heterosexuals with infectious syphilis is increasing. But there has been no increase in the number of heterosexuals with syphilis and an increasing proportion of